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FILE COPY

November 8, 2006

Rhonda Repp, Administrator
Virginia Rose Resident Inn
2525 N Maple Grove Rd
Boise, ID 83704

Dear Ms. Repp:

On November 7, 2006, a complaint investigation survey was conducted at Virginia Rose Resident Inn. The survey was conducted by Patrick Hendrickson, R.N. and Jamie Simpson, MBA, QMRP. This report outlines the findings of our investigation.

Complaint # ID00002134

Allegation #1: An identified resident was seen at the local emergency room on October 30, 2006 and was found to have a critical prothrombin time (PT), partial thromboplastin time (PTT) and international normalized ratio,(INR). The resident did not have a prescription for blood thinners, it was believed the resident had been taking another residents blood thinning medication.

Findings: Based on interview and record review it was determined the identified resident did have a critical PT, PTT, INR on October 30, 2006 and the resident did not have a prescription for blood thinners. However, it could not be determined that the resident had taken another resident's medication.

Review of the identified resident's record on November 2, 2006 revealed a Negotiated Service Agreement (NSA) dated January 9, 2006. It documented the identified resident needed extensive assistance with medications and staff were to assist the identified resident with all prescribed medications.

The identified resident's record also contained physician's orders dated September 14, 2006 that documented the resident did not have any anti-coagulation medications ordered.

The identified resident's Medication Administration Record (MAR) was reviewed on November 2, 2006. The MAR revealed the resident did not receive any documented anti-coagulation medications from October 1, 2006 through November 2, 2006.

The resident's record contained a "Caregiver Progress Note" that documented on October 30, 2006 a second resident who was receiving anti-coagulation medications stated she was

getting her medication appropriately and the identified resident "denied" taking the other residents anti-coagulation medications.

Review of the second resident's record on November 2, 2006 revealed physicians orders dated October 4, 2006 that documented the second resident was to take Coumadin 7.5 mg every day.

The second resident's Medication Administration Record (MAR) was reviewed on November 2, 2006. The MAR revealed documentation the resident received Coumadin 7.5 mg every day from October 1, 2006 thru November 1, 2006.

Review of the second resident's labs from an outpatient clinic documented the following:

- 9/6/06 INR-3.5 (normal range- 2.0 -3.0 for standard Coumadin therapy)
- 10/4/06 INR-2.5 (normal range- 2.0 -3.0 for standard Coumadin therapy)
- 11/3/06 INR-3.4 (normal range- 2.0 -3.0 for standard Coumadin therapy)

Review of the facility's "Incident/Accident Report" log on November 2, 2006 revealed on October 30, 2006 the identified resident complained to staff about multiple bruises on her body. Further it documented that staff talked to the second resident who stated she was getting her medication at 6:00 p.m. daily "with-out fail."

Review of the facility's "Medication Policy" on November 2, 2006 documented that staff were to observe all residents taking their medications.

On November 6, 2006 the identified resident's emergency department records were reviewed. The records revealed the resident was seen on October 30, 2006 for complaints of diarrhea for 1 week and bruises on her arms, legs and abdomen. She also complained of "mismanagement of her medications."

The emergency records contained lab results that documented the following:

- October 30, 2006 at 1:30 p.m.
  PT was 75.7 (normal range- 9.0 - 12.0)
  PTT was 136.6 (normal range- 22.0 - 29.6)
  INR-7.27 (normal range- 2.0 -3.0 for standard Coumadin therapy)

- October 30, 2006 at 3:50 p.m.
  PT was 76.6 (normal range- 9.0 - 12.0)
  PTT was 135.0 (normal range- 22.0 - 29.6)
  INR-7.36 (normal range- 2.0 -3.0 for standard Coumadin therapy)

The identified residents emergency room records also contained blood results from November 3, 2006 at 3:50 p.m. that documented the resident's blood was re-tested and the results were:

- PT was 9.3 (normal range- 9.0 - 12.0)
- PTT was 26.7 (normal range- 22.0 - 29.6)

- INR-0.91 (normal range- 2.0 -3.0 for standard Coumadin therapy)

The identified residents emergency room records contained a physician's history and physical dated November 1, 2006 at 9:56 a.m. that stated, " Noting the coagulation abnormalities this is concerning, I did compare previous labs February 2006 at which time she had normal protime and a PTT. This would be most concerning that she would have taken Coumadin."

On November 2, 2006 at 7:10 a.m. the identified resident was shown the second resident's Coumadin and asked if she had ever seen or taken that pill before? The identified resident stated that she had never seen the pills before and had not taken them.

On November 2, 2006 at 7:30 a.m. the second resident stated she had been assisted with her Coumadin daily and did not recall missing a dose.

On November 2, 2006 at 7:40 a.m. a caregiver at the facility who assisted with medications stated all residents who were assisted with their medications were observed taking their medications by staff. She had no knowledge of the identified resident taking another resident's anti-coagulation medications.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

PATRICK HENDRICKSON, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

PH/slc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program